Medicaid

for Low Income Families

SOBRA

Medicaid

ALL Kids

Insurance

The Alabama

Child Caring

Foundation

THIS IS YOUR APPLICATION

for free or low cost health care coverage.

These programs cover low income families with children, pregnant women, children under age 19, and females ages 19-44 for family planning/birth control service only.

Your income and family information will be the deciding factors as to which of the programs you may qualify for.

Si necesita una solicitud en Español, comuniquese con ALL Kids al teléfono **1-888-373-KIDS (5437)** (llamada sin costo) o el Alabama Medicaid Agency al teléfono **1-800-362-1504** (llamada sin costo).

Form 291 (Revised 03/2004)

Please print clearly using dark ink. Please fill out all information in each section.

1. **Applicant. This is the Parent, Caretaker, OR Pregnant Woman. (Children will be listed on Page 2.)**

First Name of Applicant Middle/Maiden Last	Social Security Number of Applicant
Mailing Address	Home Phone: ( ) Message Phone: ( )
Street Address (911 Address) County where you live	Work Phone ( ) May we call you at work? Yes ☐ No ☐
City, State, Zip Code	Other Phone ( ) Whose?
Marital Status: Married ☐ Divorced ☐ Separated ☐ Single ☐ Widowed ☐	What language do you usually speak? English ☐ Spanish ☐ Other ☐_____ Do you or a family member speak English? Yes ☐ No ☐

2. **Pregnant Woman.** (Please provide a statement from a doctor or an authorized clinic proving you are pregnant and the expected date your baby is due.)

Name	Date Baby is Due

3. **Paid or Unpaid Medical Bills. Did anyone applying go to the doctor, have lab work, or other medical expenses in the last 3 months? Yes ☐ No ☐**

Name of Patient?	When was Care Received?	Name of Patient?	When was Care Received?

4. **Health Insurance.** Does anyone applying already have health insurance (Blue Cross, other)? Yes ☐ No ☐ If yes, we need a copy of card, front and back.

Policyholder's Name	Insured Person's Name	Insurance Company	Policy #	Group #	Effective Date
Policyholder's Name	Insured Person's Name	Insurance Company	Policy #	Group #	Effective Date

Has any health insurance **ended within the last 3 months?** Yes ☐ No ☐
Will any health insurance end in the next 2 months? Yes ☐ No ☐ Coverage end date: _____
Please explain why this insurance ended, or will end, and who it affects: _____
Is any child eligible for state or public school system employees' health insurance? Yes ☐ No ☐ If Yes, who: _____

5. **Females Age 19 - 44 May be Eligible for Family Planning (Birth Control) Services. Do You Want to Apply for These Services? Yes ☐ No ☐**
6. **Do You Get a Family Assistance Check From DHR? Yes ☐ No ☐ Do You Get Food Stamps? Yes ☐ No ☐ Case Number _____**

ALL Kids Date Rec'd _____ Medicaid Date Rec'd _____ ACCF Date Rec'd _____

Date Accepted _____ Date Accepted _____ Date Accepted _____

7. Are You or Anyone in Your Household Receiving Food From the WIC Program? Yes ☐ No ☐

8. Household Members.

	On Line A, list parent, caretaker, or pregnant woman from Item 1. on page 1. **On Line B, list the spouse** of the person on Line A **On Lines C - O, list all the children who are under 19 years of age** that you take care of and who live in your home. **NOTE: If there is a legal parent to the child(ren) listed,** who lives in the home, **please include that parent in this section**. **First Name Middle/Maiden Last**	**Social Security Number** (required for those seeking assistance)	**Relationship to person on line A.** Child (C) Grandchild (I) Husband (H) Wife (W) Parent (P) Brother/ Sister (S) Niece/ Nephew (N) Cousin (E) Other (O)	**Are you a U. S. Citizen? Yes or No** (Noncitizens may still receive some services.)	**Date of Birth**	**Age**	**Sex**	**Race** Black (B) White (W) Asian (A) Hispanic (H) American Indian/ Native Alaskan (I) Native Hawaiian/ Pacific Islander (NP) Other (O) Not Known (U)
A			**Self**					
B			**Spouse**					
C								
D								
E								
F								
G								
H								
I								
J								
K								
L								
M								
N								
O								

9. Stepparents. Is there a stepparent living in the home? Yes ☐ No ☐

If yes, _____ is a Stepparent to _____
Name of Stepparent — Name of Child(ren)

_____ is a Stepparent to _____
Name of Stepparent — Name of Child(ren)

10. If Your Household Has No Income, Check Here _____.

11. Work Income For You and Your Household. For Medicaid eligibility, attach proof of gross wages (this means work income before anything is taken out), such as check stubs or a signed statement from employer for the most recent month.

NOTE: Only the income from a legal parent of a child you are applying for will be considered.

Name of Person Working	**Number of Hours Worked Each Week**	**Hourly Pay Rate**	**Day of Week Paid**	**How Often Paid?** Weekly Every two weeks Twice a month Other (specify)	**Gross Amount Paid** (Before anything is taken out) **Include Tips**	**Name of the Person or Company that You Work for, the Address and Phone Number**

Are You Self-employed? Yes ☐ No ☐ If self-employed, you must attach a copy of your most recent Income Tax Return and Schedule C.

Do You Receive Income From Farming? Yes ☐ No ☐ You must attach a copy of your most recent Income Tax Return and Schedule F.

12. Day Care. If you are working, does anyone in your household pay for care of a child or an incapacitated adult living in the home? Yes ☐ No ☐

Name of Person Who Pays	Amount Paid?	How Often Paid?	Name and Age of Person(s) in Care

13. Other Income. For Medicaid eligibility, attach proof of income such as a benefits award letter, a copy of the check, or a statement from the Income Source.
Tell us if you or any family members receive other income from the types listed below.
For child support, list the child's name as the person who gets the payment.

1. Social Security (include Medicare prem.)
2. SSI (Gold Check)
3. Public Assistance (Welfare)
4. Railroad Retirement
5. Veterans Benefits, Pensions, Compensation or Insurance
6. Federal Civil Service Annuity
7. State Retirement/Pension
8. Private Pension
9. Miner's Benefits
10. Black Lung Benefits
11. Cash Contributions (from relatives, others)
12. Rental Income (land, buildings or from roomer)
13. Personal Loans (from relatives, others)
14. Unemployment Compensation
15. Insurance Annuity or Proceeds
16. Government Payments on Land
17. Coal, Oil, Gravel Rights & Timber Leases
18. Royalties
19. Child Support
20. Interest on Savings
21. Other: Specify _____
22. Other: Specify _____
23. Legal Settlements
24. Sheltered Workshop Earnings
25. Lump Sums
26. Dividends
27. School Grants or Loans

Name of Person Receiving the Payments	**What Type (From Above)**	**Gross Amount** (before anything is taken out)	**How Often are Payments Received?**

For ALL Kids Use Only

Screen ck	All Kids ck	MCD ck	LF/NF ck	Fee pd ck	Date wk

For Medicaid Use Only

ID# _____ ID# _____ ID# _____ ID# _____

Alabama Medicaid Agency/Alabama Department of Public Health eligibility policies and procedures are in compliance with Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Federal Age Discrimination Act of 1975, and Americans With Disabilities Act of 1990.

This page is for Medicaid for Low Income Families (MLIF) only.

If you do not wish to apply for MLIF for yourself, leave this page blank.

Medicaid for Low Income Families (MLIF) is for families with very low income. MLIF will allow an adult to be included in Medicaid, however, information regarding absent parents is required for this program. If you want to apply for MLIF for yourself, you must give us the absent parent information below to allow Medicaid to send a medical support referral to the Child Support Enforcement Unit of the Department of Human Resources (DHR).

If you are applying for MLIF and there is a child in your home whose parent(s) are not living in the home, you must complete the information below about each parent not living in the home, unless you can provide Medicaid with a good reason. A good reason may be that the child was conceived through rape or incest, or that cooperating or providing information would result in harm or injury to you or your family. If you do not want to apply for MLIF or do not want to complete the absent parent information or cooperate with the Child Support Unit, your child(ren) may still be eligible for Medicaid.

Will you cooperate with the Child Support Unit for medical support enforcement? Yes ☐ No ☐
If you feel you have a good reason not to cooperate, check here _____.

Do you wish to apply for MLIF? Yes ☐ No ☐

For MLIF only, fill out as much information as you have for each child that has one or both parents not living in the home.

Name of child who has an absent parent _____				
Name of the absent parent	**Social Security Number**	**Date of Birth**	**Race**	**Sex** Male ☐ Female ☐
Address		**Reason for not living in the household**		
Have you already applied for child support or medical support for this child? Yes ☐ No ☐		**Has paternity been established for this child? Yes ☐ No ☐**		

Name of child who has an absent parent _____				
Name of the absent parent	**Social Security Number**	**Date of Birth**	**Race**	**Sex** Male ☐ Female ☐
Address		**Reason for not living in the household**		
Have you already applied for child support or medical support for this child? Yes ☐ No ☐		**Has paternity been established for this child? Yes ☐ No ☐**		

Name of child who has an absent parent ______________________________

Name of the absent parent	**Social Security Number**	**Date of Birth**	**Race**	**Sex** Male ☐ Female ☐
Address	**Reason for not living in the household**			
Have you already applied for child support or medical support for this child? Yes ☐ No ☐	**Has paternity been established for this child? Yes ☐ No ☐**			

Name of child who has an absent parent ______________________________

Name of the absent parent	**Social Security Number**	**Date of Birth**	**Race**	**Sex** Male ☐ Female ☐
Address	**Reason for not living in the household**			
Have you already applied for child support or medical support for this child? Yes ☐ No ☐	**Has paternity been established for this child? Yes ☐ No ☐**			

Name of child who has an absent parent ______________________________

Name of the absent parent	**Social Security Number**	**Date of Birth**	**Race**	**Sex** Male ☐ Female ☐
Address	**Reason for not living in the household**			
Have you already applied for child support or medical support for this child? Yes ☐ No ☐	**Has paternity been established for this child? Yes ☐ No ☐**			

Name of child who has an absent parent ______________________________

Name of the absent parent	**Social Security Number**	**Date of Birth**	**Race**	**Sex** Male ☐ Female ☐
Address	**Reason for not living in the household**			
Have you already applied for child support or medical support for this child? Yes ☐ No ☐	**Has paternity been established for this child? Yes ☐ No ☐**			

If you need more room, please attach additional sheets.

I Understand that:

- This application is only for ALL Kids, Alabama Child Caring Foundation, Medicaid for pregnant women, Medicaid for females ages 19-44 (for family planning/ birth control services only), Medicaid for children under age 19, and Medicaid for Low Income Families (MLIF) with children.
- I give permission to the Alabama Medicaid Agency, the Alabama Department of Public Health and the Alabama Child Caring Foundation to use my social security number and the social security numbers of persons on whose behalf I am applying to get information about my/our income from banks, financial institutions, employers, and other county, state and federal agencies, and/or to see if I/we qualify for assistance or to see if I/we have insurance.
- To be eligible for MLIF, I must cooperate in establishing paternity and getting medical support, unless I provide Medicaid with good reason not to cooperate.
- If I am approved for Medicaid, I assign all insurance and medical support benefits to Medicaid. If Medicaid pays my bills, then my insurance or other benefits (such as lawsuit settlements) must be used to pay Medicaid back. I agree to help and cooperate with Medicaid in identifying and collecting this money, or I may lose my Medicaid benefits. I give permission for my insurance company, employer, and others to give needed information to Medicaid in order to administer the Medicaid program.
- I (and my spouse) must apply for any benefits (such as unemployment compensation) that we may be entitled to.
- I agree to let the above named agencies know, at annual renewal, if anything in my household changes. However, if I am on MLIF, I must report any changes within ten (10) days. (The kinds of changes to report are: someone moves into or out of my home, my address changes, I/we get or lose insurance, or someone's income changes.)
- If I am approved, I agree to cooperate if I am reviewed by State and/or Federal Quality Control.
- I may request a hearing if a decision is not reached on my case within the proper time limit or if I disagree with the decision reached.

Sign Here:
I certify that all information entered on this application is true, to the best of my knowledge. If I knowingly entered any false statements or left out information asked for on this application, such as income or household members, I commit a crime that is punishable under Federal and/or State law.

Signature of applicant	Date	Signature of Spouse	Date

NOTE: If you are applying for Family Planning Services for your spouse, who is a female aged 19-44, she must sign on "Signature of Spouse" line.

Signature of person helping to fill out this form	Relationship to applicant	Date

Signature of interviewer helping to fill out this form	Date

You may mail this application to any one of the programs you are applying for. Mail to:

ALL Kids Program
P.O. Box 304839
Montgomery, AL 36130-4839
1-888-373-KIDS (5437) Toll free

Alabama Medicaid Agency (SOBRA, MLIF)
P.O. Box 5624
Montgomery, AL 36103-5624
1-800-362-1504 Toll free

The Alabama Child Caring Foundation
P. O. Box 830870
Birmingham, AL 35283-0870
1-800-726-2289 Toll free